Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586
Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Antipsychotic Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

PA is required for Risperdal M and Zyrexa Zydis. Brand-name Clozaril requires PA because it has an FDA "A"-rated generic. (Please use the Brand Name Drug Prior Authorization Request form for PA requests for brand-name Clozaril.)

PA is required for duplicative antipsychotic pharmacotherapy, or an overlap of 60 days or more in prescriptions (for any dosage form), of two or more of the following atypical antipsychotics: Abilify, Geodon, Risperdal, Seroquel, and Zyprexa. Additional information about antipsychotics can be found within the MassHealth Drug List at **www.mass.gov/masshealth**

Member information

Last name	First name	MI	MassHealth member ID no.	Date of birth	Sex (Circle one.) f m

Member's place of residence ☐ home ☐ nursing facility

Medication information

Indication for antipsychotic requested (Check one or all that apply.)

☐ Schizophrenia ☐ Bipolar disorder ☐ Other: _____

Has member been hospitalized for this condition?

☐ Yes. Dates of most recent hospitalization: _____ ☐ No

Is member under the care of a psychiatrist? ☐ Yes ☐ No

Name of psychiatrist: _____ Telephone no.: _____

Date of last visit with psychiatrist: _____

Section I

Please complete Section I for a PA request for any of the following:

☐ Risperdal M
☐ Zyrexa Zydis
☐ Other: _____

Dose, frequency, and duration of requested antipsychotic	Drug NDC (if known) or service code

Please explain rationale for requested dosage form(s) or other.

_____

_____

Has member tried other medications to treat this condition?

☐ Yes. Please provide details of previous treatment(s), including drug name(s), dates of use and response to treatment(s).

_____

_____

☐ No. Explain why not.

_____

_____

Please list all other psychotropic medications currently prescribed for this member.

_____

_____

over ▶

Medication information (cont.)

Section II

Please complete Section II for a PA request due to duplicative antipsychotic pharmacotherapy.

- ☐ Abilify (aripiprazole)
- ☐ Geodon (ziprasidone)
- ☐ Risperdal (risperidone)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzapine)

Dose, frequency, and duration of first requested antipsychotic	Drug NDC (if known) or service code
Dose, frequency, and duration of second requested antipsychotic	Drug NDC (if known) or service code

Please describe trial with each individual agent as monotherapy and start dates.

Please list all other psychotropic medications currently prescribed for the member.

Pharmacy information

Name	Pharmacy provider no.	Telephone no. ( )	Fax no. ( )	
Address		City	State	Zip

Prescriber information

Last name	First name	MI	MassHealth provider no.	DEA no.	
Address			City	State	Zip
E-mail address			Telephone no. ( )	Fax no. ( )	

Signature

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (Stamp not accepted.) Date